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{N 000}	Initial Comments A follow-up survey to the Plan of Correction (PoC) was completed 3/23/2020 to 3/24/2020 at Green Hills Center for Rehabilitation and Wellness. No deficiencies were cited related to follow-up survey under Chapter 1200-8-6, Standards for Nursing Homes.	{N 000}		

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N 000	Initial Comments The licensure survey and complaint investigation #TN00050307 were completed on 2/7/2020 at Green Hills Center for Rehabilitation and Healing. Deficiencies were cited related to the licensure survey under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		
N 682	1200-08-06-.06(4)(f) Basic Services (4) Nursing Services. (f) The facility must ensure that an appropriate individualized plan of care is prepared for each resident with input from appropriate disciplines, the resident and/or the resident ' s family or the resident ' s representative. This Rule is not met as evidenced by: Based on facility policy review, medical record review, observation, and interview the facility failed to develop and implement a person-centered care plan for 3 of 41 residents (Resident #60, #4 and #57) reviewed for Comprehensive Care Plans placing the residents in Immediate Jeopardy (IJ) (a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident). Resident #60 experienced a fall which resulted in a C7 fracture (fracture of the 7th neck vertebra) and a second fall which resulted in a Proximal Left Hip Fracture (Fracture at the base of the Femoral Neck). Resident #4 experienced a fall which resulted in a Traumatic Subarachnoid Hemorrhage (bleeding in the space between the brain and the tissue covering the brain related to trauma). Resident #4 then developed a new onset of seizure activity after	N 682	**N682 1200-08-06-.06(4)(f) Basic Services** See F 656	

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N 682	Continued From page 1 the fall. Resident #57 was left unattended in the bathroom, fell while self-toileting and sustained a Left Humerus (upper arm) Fracture. The Administrator was notified of the Immediate Jeopardy (IJ) on 2/4/2020 at 10:05 PM in the Director of Nursing's (DON) office. N-682 1200-806-.06(F) was cited at a scope and severity of "K". An extended survey was conducted from 2/4/2020 through 2/7/2020. The Immediate Jeopardy was effective from 7/3/2019 to 2/6/2020. An Immediate Action Removal plan which removed the immediacy of the jeopardy was received on 2/7/2020 at 12:30 PM and corrective actions were validated on site by the surveyors on 2/7/2020. The findings include: Review of the medical record, revealed Resident #60 was admitted to the facility on 3/14/2016 with diagnoses which included History of Falling, Dementia without Behavior Disturbance and Difficulty in Walking. Further review showed the resident was readmitted on 7/5/2019 with a new diagnosis of Displaced Fracture of Seventh Cervical Vertebra (C7 Fracture), Unsteadiness on Feet and Orthostatic Hypotension. Continued review showed a new diagnosis was added on 12/1/2019, Unspecified Fall. Further review showed a new diagnosis was added on 12/24/2019, Displaced Fracture of Base of Neck of Left Femur (L Proximal Hip Fracture).	N 682		

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N 682	Continued From page 2 Review of the Quarterly Minimum Data Set (MDS) dated 4/9/2019, revealed Resident #60 had severe cognitive impairment, his vision is highly impaired, he required supervision with ambulation and most other activities of daily living (ADLs) and required limited assistance with transferring from a chair to a standing position with one person physical assistance. Review of the fall risk assessment dated 3/15/2019, and 4/9/2019, revealed Resident #60 was assessed at a high risk for falls. Review of Resident #60's Comprehensive Care Plan revealed no interventions for supervision with ambulation per MDS dated 4/9/2019. Review of the interdisciplinary post fall review dated 7/3/2019, revealed "...Resident #60 fell on 7/3/2019, he was found in a supine position on the floor in another resident's room...the fall was unwitnessed..." Review of the fall risk assessment dated 7/10/2019 and 12/1/2019, revealed Resident #60 continued to be at high risk for falls. Review of Resident #60's undated Comprehensive Care Plan revealed there were no interventions for supervision with ambulation after the falls on 7/3/2019 and 12/23/2019. Review of the fall risk assessment dated 12/6/2019, revealed Resident #60 continued to be at high risk for falls. Review of the Quarterly MDS assessment dated 12/6/2019, revealed Resident #60 had severe cognitive impairment, his vision was highly impaired, and he required 1 person physical	N 682		

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N 682	Continued From page 3 assistance with most of his ADLs. Review of the interdisciplinary post fall review dated 12/24/2019, revealed Resident #60 had an unwitnessed fall on 12/23/2019. The resident was found in the doorway of another resident's room. Review of Resident #60's Comprehensive Care Plan interventions revealed no interventions for the resident requiring 1 person assistance with ambulation were added after the fall on 12/23/2019. Review of Resident #60's radiology report dated 12/24/2019, revealed "...Proximal left hip fracture..." Review of the MDS Comprehensive Assessment on 1/3/2020, revealed Resident #60 had severe cognitive impairment, his vision was highly impaired, and he needed extensive assistance with all of his ADL, and walking activity did not occur. The resident had a fall with major injuries and was referred to hospice services post fall. Observation on 2/4/2020 at 8:42 AM, revealed Resident #60 was sitting up in his wheelchair in the day room, his eyes were open, but he did not interact with others. During an interview on 2/5/2020 at 4:45 PM, Certified Nursing Assistant (CNA) #4 stated after the fall on 12/23/2019, "...Resident #60 had a drastic change in functional status..." During an interview on 2/6/2020 at 3:15 PM, Registered Nurse (RN) #3 stated Resident #60 had a fall on 12/23/2020, which resulted in a Left Hip Fracture. During continued interview RN #3 stated the resident was unable to ambulate after	N 682		

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N 682	Continued From page 4 the fall. Review of the medical record revealed Resident #4 was admitted to the facility on 4/16/2019, with diagnoses which included Dementia without Behavior Disturbance and Altered Mental Status. Further review showed the resident was readmitted on 10/10/2019, with new diagnoses of Traumatic Subarachnoid Hemorrhage and Post Traumatic Seizures. Continued review showed a new diagnosis for Repeated Falls was added on 11/11/2019. Review of the Quarterly Minimum Data Set (MDS) dated 4/24/2019, revealed Resident #4 was rarely or never understood, locomotion on the unit required extensive assistance with a 2 person physical assistance; and walking in room did not occur. Review of the fall risk assessments dated 4/10/2019, 4/27/2019, and 7/23/2019, revealed Resident #4 was at high risk for falls. Review of the post fall reports revealed Resident #4 had an unwitnessed fall on 7/23/2019, with no injuries. Review of the Comprehensive Care Plan for Resident #4 revealed no interventions for supervision and assistance with ambulation. Review of the Quarterly MDS dated 7/25/2019, revealed Resident #4 was rarely or never understood and walking in the room and corridor required supervision. Review of the fall risk assessment dated 7/25/2019, and 10/7/2019, revealed Resident #4 continued to be at high risk for falls.	N 682		

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N 682	Continued From page 5	N 682		

Review of the post fall interdisciplinary review dated 10/8/2019, revealed "...Resident #4 had a fall with injuries on 10/7/2019 which resulted in Traumatic Subarachnoid Bleed..."

Review of the Comprehensive Care Plan revealed the following intervention was added on 10/7/2019, "...Transfer to ER [emergency room] for further evaluation and treatment as indicated..."

Review of the fall risk assessment dated 10/10/2019, revealed Resident #4 continued to be at high risk for falls.

Review of the Quarterly MDS dated 10/25/2019 revealed Resident #4 was rarely or never understood and ambulation in the room and in the corridor required supervision with 1 person physical assistance.

Review of Resident #4's Comprehensive Care Plan revealed no interventions for supervision or assistance with ambulation were added after the following falls: 7/23/2019, 10/7/2019 and 11/10/2019.

Review of the Interdisciplinary Post Fall Review dated 11/10/2019, revealed Resident #4 had an unwitnessed fall on 11/10/2019.

Review of the fall risk assessment dated 11/18/2019, revealed Resident #4 continued to be at high risk for falls.

During an interview on 2/5/2020 at 3:18 PM, Nurse Practitioner #1 confirmed Resident #4's fall on 10/7/2019, was unwitnessed. There were no neurological changes before the fall and he did

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N 682	Continued From page 6	N 682		

not have a history of seizures prior to his fall on 10/7/2019.

Review of the medical record revealed Resident #57 was admitted to the facility on 7/17/2019, with diagnoses which included Dementia Without Behavioral Disturbances, Major Depressive Disorder, Bipolar Disorder, Hemiplegia and Hemiparesis Following Cerebral Infraction Affecting Left Non-Dominant Side, and Dysphagia.

Review of Resident #57's comprehensive care plan dated 7/18/2019, revealed "...I require Mechanical Lift with 2 staff assistance for transfers...I need moderate asst. (assistance) from one person to toilet...I need moderate asst. (assistance) to perform hygiene..."

Review of Resident #57's Quarterly Minimum Data Set (MDS) dated 12/21/2019, revealed Resident #57 had a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. Further review revealed Resident #57 required extensive assistance with 1 person physical assist with transfers, toileting use, and personal hygiene.

Review of Resident #57's Significant Change MDS dated 1/3/2020, revealed Resident #57 had a BIMS score of 3, indicating severe cognitive impairment. Further review revealed Resident #57 required extensive assistance with 1 person physical assist with transfers, major injury since admission.

Review of Resident #57's Interdisciplinary Post Fall Review dated 12/24/2019, revealed "...unwitnessed fall...resident was attempting to wipe herself after a bowel movement...resident

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N 682	Continued From page 7 found on the floor of the bathroom when Certified Nursing Assistant [CNA] #2 returned to the room..." Review of Resident #57's fall report dated 12/24/2019 revealed "...patient tried to stand up to wipe herself after having a bowel movement and fell...gait imbalance...unaware of physical limitations...history of falls...[named CNA 2] was educated per [by] the Unit Manager regarding the importance of staying near the bathroom or outside the door to promote safety while providing privacy..." During a telephone interview on 2/4/2020 at 8:39 PM, CNA #2 stated she assisted Resident #57 to the bathroom on 12/24/2019. She stated, "At the request of the resident, I assisted her to the bathroom without the use of a mechanical lift or anyone else. During shift change I was verbally briefed by outgoing staff [Resident #57] was a 1 person physical assist for toileting." During continued interview, CNA #2 stated "I relied on outgoing staff to brief me on the residents care needs or I ask a resident what their care needs were for the shift. I didn't look at her care plan." During an interview on 2/5/2020 at 6:30 PM with the Director of Nursing (DON), Administrator, they stated they believed the care plan interventions in place for 3 Residents (#4, #57 and #60) were adequate to keep these residents safe. The Immediate Action Removal Plan was verified by the surveyors on 2/7/2020 by: 1. The surveyors verified through review of care plans and staff interviews the care plan interventions were implemented for Residents #4, #57 and #60. Resident #4's Care Plan was was	N 682		

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N 682	Continued From page 8 updated to reflect staff will offer assistance with ambulation. Resident #57's Care Plan was updated to reflect she required moderate assistance with toileting. Resident #60's Care Plan was updated to include bilateral fall mats when in bed and bed in low position. 2. The surveyors verified all safety interventions were in place for 3 residents (#4, #57 and #60). The surveyors verified the facility's 100% audit of residents who were at risk for falls and reviewed the care plans for the residents at risk. 3.The surveyors reviewed and verified the Fall Prevention and ADL's/Functional Status education and training was completed for the Certified Nursing Assistants who were present (90% of the CNA staff) on 2/6/2020. The remaining 10% will receive education by 2/10/2020. The surveyors verified the facility held an AdHoc/QAPI meeting (an immediate meeting by Administrative staff to address the immediate situation) on 2/5/2020 to include discussion related to fall prevention and care plan implementation. The facility's noncompliance at F-656 continues at a scope and severity of "E" for the monitoring of the effectiveness of the corrective actions. The facility is required to submit a Plan of Correction.	N 682		
N1102	1200-8-6-.11(2) Records and Reports (2) The nursing home shall report all incidents of abuse, neglect, and misappropriation to the Department of Health in accordance with T.C.A. § 68-11-211.	N1102	**N1102 1200-8-6-.11(2) Records and Reports** See F609	3/2/20

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N1102	Continued From page 9	N1102		

This Rule is not met as evidenced by:
Based on facility policy review, medical record review and interview, the facility failed to report resident to resident altercations to the state agency for 4 of 4 resident to resident altercations reviewed.

The findings include:

Review of the facility policy titled, Abuse and Neglect Prohibition, revised August 2017, revealed "...The facility will report all allegations and substantiated occurrences of abuse, neglect, exploitation, mistreatment including injuries of unknown origin, and misappropriation of property to the administrator, State Survey Agency, and law enforcement officials and adult protective services (where state law provides for jurisdiction in long-term care facilities) in accordance with Federal and State law through established procedures..."

Review of the medical record, revealed Resident #4 was admitted to the facility on 4/16/2019 and readmitted on 10/10/2019 with diagnoses which included Alzheimer's Disease, Altered Mental Status and Dementia.

Review of Resident #4's nurses progress note dated 7/23/2019 revealed the resident was involved in an altercation with an unnamed resident.

Review of the medical record, revealed Resident #13 was admitted to the facility on 10/30/2018

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N1102	Continued From page 10 with diagnoses which included Altered Mental Status, Cognitive Communication Deficit, Vascular Dementia without Behavioral Disturbances and Anxiety. Review of Resident #13's nurses progress note dated 11/26/2019 revealed the resident was involved in two altercations with an unnamed resident. Review of the medical record, revealed Resident #60 was admitted to the facility on 3/14/2016 with diagnoses which included Unspecified Dementia without Behavioral Disturbance, History of falling and difficulty in walking. Review of Resident #60's nurses progress notes revealed the resident was involved in an altercation with an unnamed resident on 10/21/2019 and 11/21/2019. Review of the medical record, revealed Resident #173 was admitted to the facility on 2/6/2019 with diagnoses which included Heart Failure, Anemia, Osteoarthritis, Peripheral Disease and Weakness. Review of Resident #173's nurses progress note revealed the resident was involved in an altercation with an unnamed resident on 4/8/2019. During an interview on 2/5/2020 at 5:30 PM, the Director of Nursing (DON) and the Administrator confirmed the facility had not reported any resident to resident altercations to the state agency in 2 years.	N1102		

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N1207	Continued From page 11	N1207		
N1207	1200-8-6-.12(1)(g) Resident Rights (1) The nursing home shall establish and implement written policies and procedures setting forth the rights of residents for the protection and preservation of dignity, individuality and, to the extent medically feasible, independence. Residents and their families or other representatives shall be fully informed and documentation shall be maintained in the resident's file of the following rights: (g) To be free from mental and physical abuse. Should this right be violated, the facility must notify the department within five (5) working days. The Tennessee Department of Human Services, Adult Protective Services shall be notified immediately as required in T.C.A. §71-6-103; This Rule is not met as evidenced by: Based on facility policy review, medical record review, and interview, the facility failed to ensure 3 of 4 sampled residents (Resident #4, #13, and #60) reviewed involved in resident to resident altercations were free from abuse. The findings include: Review of the facility policy titled, Abuse and Neglect Prohibition, revised August 2017, revealed "...Each resident has the right to be free from abuse, neglect, mistreatment, injuries of unknown origin, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms..." Review of the medical record, revealed Resident	N1207	**N1207 1200-8-6-.12(1)(g) Resident Rights** See F550	3/2/20

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N1207	Continued From page 12 #4 was admitted to the facility on 4/16/2019 and readmitted on 10/10/2019 with diagnoses which included Alzheimer's Disease, Altered Mental Status and Dementia. Review of Resident #4's nurses progress note dated 7/23/2019 revealed "...Resident yelled out, as he was on the floor in room lying on his back. This writer asked resident B what happened, and he stated that he pushed him. When asked why did he do that, resident B stated that resident A pushed him first..." Review of the medical record, revealed Resident #60 was admitted to the facility on 3/14/2016 with diagnoses which included Unspecified Dementia without Behavioral Disturbance, History of falling and difficulty in walking. Review of Resident #60's nurses progress note dated 10/21/2019 revealed "...Pt [patient] was found in his room sitting quietly when another resident was witnessed going into this residents room and kicked him in the groin..." Review of Resident #60's nurses progress note dated 11/21/2019 revealed "...Resident was in his room lying in bed when was struck in the abdomen by another resident who purposefully came into room..." Review of the medical record, revealed Resident #173 was admitted to the facility on 2/6/2019 with diagnoses which included Heart Failure, Anemia, Osteoarthritis, Peripheral Disease and Weakness. Review of Resident #173's nurses progress note dated 4/8/2019 revealed "...Resident came into close proximity to an agitated resident to probably	N1207		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN1916	A. BUILDING: _____ B. WING _____	02/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN HILLS CENTER FOR REHABILITATION	3939 HILLSBORO CIRCLE NASHVILLE, TN 37215

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N1207	Continued From page 13 check on her, at which time other resident made physical contact with skin of her left side face..." During an interview on 2/5/2020 at 5:30 PM the Director of Nursing (DON) and the Administrator confirmed the facility did not consider resident to resident altercation between dementia residents to be abuse and had not reported any resident to resident altercation to the state agency in the last 2 years.	N1207		